

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2025

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/18/2025	
NAME OF PROVIDER OR SUPPLIER GENTRY PARK				STREET ADDRESS, CITY, STATE, ZIP COD 901 S HASTINGS DR BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R 0000 Bldg. 00	<p>This was an offsite Licensure Investigation Survey</p> <p>Survey Date: February 18, 2025</p> <p>Facility: #013766</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed February 18, 2025</p>			R 0000			
R 9999 Bldg. 00	<p>16.2-5-1.1 Licenses</p> <p>(1) The facility shall submit a renewal application to the director at least forty-five (45) days prior to the expiration of the license.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on document review, the facility failed to ensure it had timely renewed their license to operate as a residential care facility before their current license expired on January 31, 2025.</p> <p>The agency received the facility's renewal application and payment post marked February 2, 2025, which was not at least 45 days of the current license expiration date of January 31, 2025.</p>			R 9999	<p>R9999</p> <p>What corrective action will be accomplished for the deficient practice.</p> <p>The facility will ensure that the facility annual renewal application will be submitted timely to ensure submission 45 days prior to expiration of existing license. The Administrator will submit completed license renewal and submit the application and payment 45 days prior to expiration of current license.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.</p>		02/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Elizabeth Holstein

Executive Director

02/25/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2025

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/18/2025	
NAME OF PROVIDER OR SUPPLIER GENTRY PARK				STREET ADDRESS, CITY, STATE, ZIP COD 901 S HASTINGS DR BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					<p>The Administrator will initiate and direct the completion of the renewal form and payment to ensure submission 45 days prior to expiration of current license. This will include coordination to get ownership information updated and check request processed in a timely manner.</p> <p>How the corrective action swill be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Administrator will process the application renewal form as soon as it is received from the Indiana Department of Health. The Administrator will monitor beginning in November 2025 for the application form arrival and will work to complete and submit application by December 15, 2025.</p> <p>By what date the systemic changes will be completed. The effective date of this correction is February 25, 2025.</p>		